Family Healthcare of Hagerstown
201 S. Cleveland Ave
Hagerstown, MD 21740
o: 301-745-3777
f: 833-450-3533

FAMILY HEALTHCARE OF HAGERSTOWN

FHH Registration & UDS Information

Please note that the information provided on this form is valid for one year from the date of completion.

GENERAL INFORMATION			
I am registering for (select all that apply): □Family Practice □Mental Health □Dental			**Date of Birth:**
Last Name:	**First Name:**		**Middle Name:**
SSN:	**Sex Assigned at Birth:** □M □F	**Preferred Language:**	
If patient is school aged, what school do they attend?			
Home Address: ______ Street Address	______ City	______ State	______ Zip Code
Mailing Address: ______ Street Address	______ City	______ State	______ Zip Code
Home Phone:	**Mobile Phone:**	**Email Address:**	
I consent to receive (select all that apply): □Calls on home phone □Calls on mobile phone □ Texts on mobile phone □Emails			

Marital Status (select one):	**Race:**			**Ethnicity:**
□Single □Polygamous	□Chinese	□Japanese	□Other Pacific Islander	□Chicano □Other Hispanic/Latino
□Married □Legally Separated	□Korean	□Vietnamese	□American Indian/ Alaskan Native	□Cuban □Not Hispanic/Latino
□Widowed □Domestic Partnership	□White	□Other Asian		□Mexican □Unknown
□Divorced □Interlocutory	□Samoan	□Native Hawaiian	□Black/African American	□Puerto Rican
□Annulled □Unknown	□Filipino	□Guamanian/Chamorro	□Uknown	□Mexican American

EMERGENCY CONTACT (DOES NOT IMPLY AUTHORIZATION FOR HIPPA/PHI DISCLOSURE)		
Name:	**Relationship:**	**Phone #:**

GUARANTOR/RESPONSIBLE PARTY			
Last Name:	**First Name:**		**Middle Name:**
Address: ______ Street Address	______ City	______ State	______ Zip Code
Phone #:	**Relation to Patient:**	**DOB:**	**Sex at Birth:** □M □F

MEDICAL INSURANCE INFORMATION		
Name of Insurance Company:		**Policy #:**
Policy Holder's Name:	**Policy Holder's DOB:**	**Policy Holder's SSN:**
Employer:		**Group #:**

DENTAL INSURANCE INFORMATION		
Name of Insurance Company:		**Policy #:**
Policy Holder's Name:	**Policy Holder's DOB:**	**Policy Holder's SSN:**
Employer:		**Group #:**

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Advanced Directives:

Walnut Street Community Health Center, Inc. does business as Family Healthcare of Hagerstown (FHH). This health center receives funding through Health and Human Services (HHS) and is a grantee under 42 U.S.C. 254b. FHH has Federal Public Health Services (PHS) deemed status related to certain health or health-related claims under 42 U.S.C. 233(g)-(n). This includes medical malpractice claims for itself and its covered individuals. FHH is a nonprofit organization under section 501(c)3 of the IRS Code. This institution is an equal opportunity provider and employer.
Revised: 3/2026

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An Advanced Directive is a form that states how much medical care you want to receive in the event that you are unable to respond.

Do you have an Advanced Directive? ☐ Yes ☐ No

Who provides routine care for the patient? ☐ Self (patient) ☐ Parent ☐ Other: Name and Phone Number: _________

Legal Guardian/Healthcare Proxy:

A Legal Guardian or Healthcare Proxy is a person decided by the patient, family or court to make healthcare decisions for the patient if the patient is unable to do so.

Does the patient have a Legal Guardian or Healthcare Proxy?

☐ No ☐ Yes Name: Relationship to Patient: Phone Number:

If you have a provider you would like to be scheduled with, please write their name here: ___________________________

- I authorize Family Healthcare of Hagerstown to contact the Emergency Contact listed in this form in the event that I am unresponsive or cannot be reached and the information needing to be shared with me is imperative and/or time sensitive. I understand that listing this person above does not authorize FHH to disclose any information regarding my appointments, treatments, etc. and that I must complete a separate Release of Information form to appoint individuals authorized to receive this information.
- I understand that a separate Release of Information on which the specific facility is named is required for any medical records release or acquisition.
- I authorize Family Healthcare of Hagerstown to leave messages relating to appointment reminders and/or clinical results or information on any phone numbers provided belonging to the patient or legal guardian (excludes Emergency Contacts phone number).
- My signature below indicates that all the information provided on this form is true and correct.

____ ____________________

Signature of Patient/Parent/Legal Guardian/Healthcare Proxy Date

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In order to continue offering a variety of services and receive grant funding at FHH, we are required to collect the following information on every person that receives care at our facility.

This information is reported as an overall number and is not reported on individual patients.

How many people live in your household? _____________

What is the annual income of all family members in your household? $________________

Have you or anyone in your household done agricultural (farm) work in the last 24 months? ___________

If yes, was it migrant farm work (establish temporary home for employment)? ____________

If yes, was it seasonal farm work (do not establish a temporary home for employment)? ____________

Are you homeless? _______________

If yes, where did you stay/sleep last night? __________________

Do you live in public housing? _______________________

Are you a veteran? ____________________

FHH Consent Form

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Patient Name: ______________________________________ **Date of Birth:** ______________________

Consent to Treat:

I consent to the treatment and procedures that may be performed during my appointment. I have the right to make informed decisions about my healthcare, including the refusal of a treatment or procedure. I understand healthcare students may participate in my care.

Consent to Share Medical Record/Personal Health Information:

I understand that my medical record and/or related personal health information may be shared with the different departments of Family Healthcare of Hagerstown and also with offices that support my care. This information will be shared only to help in my health care assessment and management. Examples of this might be information related to/from pharmacies, laboratories, and referral specialists. I understand that at any time during the course of my medical treatment, if a referral to a specialist is required, certain laboratory results and/or details from the medical record could be forwarded to the specialist. This will be done solely to assist in my complete evaluation.

Acknowledgement of Patient Guidelines, Rights, and Responsibilities:

I acknowledge that I have received the Patient Information Guidelines and Patients' Rights and Responsibilities and agree to abide by the policies of Family Healthcare of Hagerstown.

Confidentiality:

I understand that Family Healthcare of Hagerstown adopts a very strict policy regarding privacy and confidentiality of my medical information. I have been given information regarding the Notices of Privacy Practices. I understand that calls with Family Healthcare of Hagerstown may be recorded, excluding any calls with a provider or management staff.

Medical Insurance Authorization and Assignment:

I understand all charges are due at the time professional services are rendered. I understand I am responsible for any amount not covered by insurance, to include co-pays and fees. I understand that Financial Assistance is available to qualifying patients. I authorize Family Healthcare of Hagerstown and all its included entities, to furnish information to my insurance carriers concerning my illness and treatments. For those services provided and submitted to my insurance company, I hereby authorize payment of medical benefits to Walnut Street Community Health Center, Inc., DBA Family Healthcare of Hagerstown.

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions. You may "opt out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or by completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org.

I understand that this consent and information, in its entirety, will remain in effect for one year.

____

Printed Name of Signee

____ _______________________________

Patient/Parent/Legal Guardian Signature Date

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